October 2004 Annual Enrollment Edition - Not Available After January 1, 2005

The Insurance Advantage

South Carolina Budget and Control Board — Employee Insurance Program

Welcome

Welcome to the 2004 issue of the *Insurance Advantage*. This newsletter will guide you through the annual enrollment process to help you decide which health plan is the best fit for you and your family.

The *Insurance Advantage* will be useful to you throughout the annual enrollment period of October 1-31, 2004. In January, you will receive the 2005 *Insurance Benefits Guide*, which will be your primary source for comprehensive information on all of the benefits programs offered through EIP.

Remember, all changes you make during the annual enrollment period will be effective beginning January 1, 2005.

Inside

More choices, more options, more savings

Introducing the new State Health Plan Savings Plan

Are you willing to take greater financial responsibility for your healthcare in return for lower insurance premiums? If so, you may be interested in the State Health Plan's Savings Plan, which will replace the Economy Plan on January 1, 2005.

A subscriber to any health plan offered through the Employee Insurance Program (EIP) may switch to the new plan in October. However, retired subscribers who are eligible for Medicare are not eligible for the SHP Savings Plan or the Health Savings Account associated with it. (Please see "What is a Health Savings Account?" on page 4 for details.) **If you are enrolled in the Economy Plan, you must choose another plan. If you fail to do so, you and your covered family members will not be covered as of January 1, 2005.** If you have refused health coverage in the past, you may enroll yourself and your eligible dependents in the Savings Plan only.

This new plan is part of EIP's effort to continue to provide economical health insurance in the face of rising medical costs. Because the Savings Plan has a high deductible, subscribers who have no other health coverage may make tax-free deposits in a Health Savings Account (HSA). The account can be used to pay qualified healthcare expenses.

What will it cost?

Monthly premiums also are a savings. They will be $9.28 for the employee, $72.56 for the employee/spouse, $20.28 for the employee/children and $108.56 for full family coverage. See pages 8-9 for other health plan rates.

The deductible, the amount you must pay out-of-pocket before the plan begins to pay benefits, will be $3,000 for subscriber-only coverage and $6,000 for subscriber/spouse, subscriber/children and full family coverage. If more than one family member is covered, no individual may receive benefits other than preventive care until the $6,000 deductible has been met.

Covered expenses for medical care and prescription drugs accumulate toward meeting the plan deductible.

What are the benefits?

After the deductible is met, the plan will pay 80 percent of the allowable charges for care given by network providers and 60 percent of the allowable charges for out-of-network providers. The out-of-pocket maximum (the amount that must be paid in coinsurance before the Savings Plan begins to pay 100 percent of allowable charges) will be $2,000 for subscriber-only coverage and $4,000 for subscriber/spouse, subscriber/children and full family coverage. This maximum applies only to services from network providers. There is no out-of-pocket maximum for services received out-of-network.

For prescription drugs, enrollees will pay 100 percent of the allowable cost at participating pharmacies, and these costs will be applied to the deductible and out-of pocket maximum. For example, in July 2004, the allowable cost for a 30-day supply of Nexium 20 mg #30, a brand-name acid reducer, was $127.59. After the deductible has been met, the enrollee will continue to pay the full allowable cost at participating pharmacies. However, the plan will reimburse him for 80 percent of the allowable cost.

Covered persons will also receive an allowance for an annual flu shot that will typically pay the full cost of this service. Enrollees under 12 will receive the Well Child Care benefits that are part of the Standard Plan. Those 12 and over will receive an

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What you need to know for annual enrollment

Getting started

During the October 1-31, 2004, annual enrollment period, you can change your health insurance plan for the coming year. To make the best decision, start by taking a look at your benefits statement to get a clear picture of the health insurance coverage you have currently. If you are satisfied with your current plan and would like to stay in the same health plan for 2005, you do not have to do anything. You will be re-enrolled automatically in your current plan if you do not elect another health plan during annual enrollment and if the plan is offered for 2005.

If you are enrolled in the State Health Plan (SHP) Economy Plan or Companion-CHOICES POS, which will not be available in 2005, you must choose another health plan during the October annual enrollment. SHP Economy Plan subscribers who fail to enroll in a different health plan for 2005 will not have health insurance effective January 1. Companion-CHOICES POS subscribers who fail to change to a different health plan for 2005 will be enrolled in Companion HMO by default.

Important annual enrollment reminders

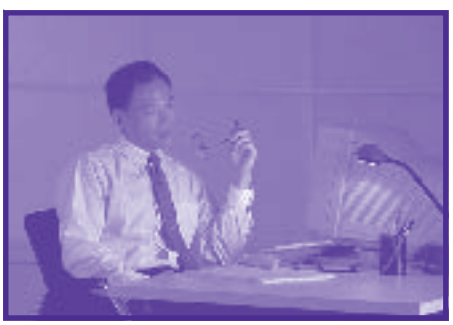
- **All changes you make during the annual enrollment period will be effective beginning January 1, 2005.**
- If you are enrolled in the State Health Plan (SHP) Economy Plan – You must choose another health plan option, because the Economy Plan will not be offered in 2005. If you fail to enroll in a different plan during the annual enrollment period, you will not have health insurance coverage beginning January 1, 2005.
- If you are enrolled in Companion-CHOICES POS – You must choose another health plan option, because Companion-CHOICES POS will not be offered in 2005. If you fail to change to a different plan during the annual enrollment period, you will be enrolled in Companion HMO by default, effective January 1, 2005.
- To maintain your same coverage – If you are not enrolled in the SHP Economy Plan or Companion-CHOICES POS, and would like to stay enrolled in the same health plan for the coming year, you do not need to take any action to maintain that coverage. You will be re-enrolled in your current plan automatically.
- To change your health plan – If you will be changing your health plan for 2005, you must complete a Notice of Election form, electing your desired changes. You can get a Notice of Election form from your benefits administrator or on the EIP Web site. To fill out a form online, visit www.eip.sc.gov, choose your category, then click on "Forms." Subscribers without Internet access may call the Employee Insurance Program at one of the numbers listed on page 11 to request a Notice of Election form.
- If you enroll in a Health Maintenance Organization (HMO) – Make sure it is offered in a county where you live or work. For more information on which counties offer the HMOs, see the chart on pages 6-7 of this newsletter.
- To participate in MoneyPlu$ accounts in 2005 – You must enroll or re-enroll in MoneyPlu$ Medical Spending or Dependent Care accounts during annual enrollment. Remember, only active employees are eligible to participate in MoneyPlu$ accounts. To participate in the Medical Spending Account, you must have completed one year of continuous state service by January 1, following annual enrollment.
- MoneyPlu$ administrative fees – Each benefit has a small administrative charge that is deducted from your paycheck before taxes and is minimal compared to your tax savings. The administrative fees for 2005 are $.12 per month for the Pretax Group Insurance Premium Feature, $2.50 per month for the Dependent Care Spending Account and $2.50 per month for the Medical Spending Account.

What you can do during annual enrollment

- Change health plans. Your health plan options for 2005 are: the SHP Standard Plan, the SHP Savings Plan, Companion HMO, CIGNA HMO, MUSC Options and the TRICARE Supplement Plan.
- Subscribers who change to the new SHP Savings Plan can also increase their level of coverage by adding dependent(s) to their health insurance coverage (for example, change from subscriber-only coverage to subscriber/children, subscriber/spouse or full family coverage) during this annual enrollment period only. Even eligible employees who have refused health insurance coverage in the past may enroll in the SHP Savings Plan and add dependents this annual enrollment.
- Subscribers who are currently enrolled in a health plan and are eligible for TRICARE may enroll in the TRICARE Supplement Plan. Employees and retirees who are eligible for Medicare are not eligible for the TRICARE Supplement.
- Active employees can apply for coverage in the Long Term Care program by providing medical evidence of good health.
- Employees may apply for coverage in Supplemental Long Term Disability by providing medical evidence of good health.
- Employees may enroll or make changes to their coverage under the Optional Life program. Please see page 3 for details on the changes you can make to your Optional Life Insurance coverage.

What you cannot do during annual enrollment

- You cannot add or drop health or dental coverage for yourself or your dependents, except for the SHP Savings Plan, as noted above.



Your health plan choices

There are some changes in the choices of health plans offered for 2005. Please see the descriptions below for information about each health plan option and for the locations of detailed articles on each one.

- **The State Health Plan** – There will be two SHP options available for 2005: the SHP Standard Plan and the SHP Savings Plan. These plans are offered statewide to all eligible subscribers and eligible retirees. For more details on the SHP plans, see pages 1 and 4.
- **HMOs** – There will be two HMOs available for 2005: CIGNA HMO and Companion HMO. Please see page 5 for details on these plans.
- **HMO with Point of Service (POS) Option** – There is one HMO with a POS option available for 2005: MUSC Options. See page 5 for details on MUSC Options. **Please note that Companion-CHOICES POS will not be available for 2005.**
- **TRICARE Supplement** – The TRICARE Supplement Plan is available to active employees, survivors and non-Medicare eligible retirees who are eligible for TRICARE, the Department of Defense's health insurance program for the military community.

Notes for retirees

- You cannot change to or from the Medicare Supplemental Plan during annual enrollment. The next opportunity to drop coverage or enroll in the Medicare Supplemental Plan will be during the next open enrollment period in October 2005.
- **Remember:** If you or your covered dependents become entitled to Medicare before age 65 (for example, because of a disability), you must notify EIP within 31 days of receiving notification of Medicare entitlement for proper enrollment and premium adjustments. If you are enrolled under the retiree group, enrollment in Medicare Part A and Part B is necessary to ensure maximum coverage and coordination of benefits.

Adjust your Optional Life coverage for 2005

Have you been considering enrolling in, or making changes to your Optional Life coverage? Annual enrollment is the time to do it. Some of the changes you can make during annual enrollment will require medical evidence of good health. You should provide this evidence by filling out a Personal Health Statement and submitting it to your benefits administrator. You can fill out a Personal Health Statement online by visiting the Employee Insurance Program Web site at www.eip.sc.gov. Choose your category, then click on "Forms" and scroll down to the "Life Insurance" section and click on "Personal Health Statement." Below is a list of changes you can make during this annual enrollment period:

- Employees can increase Optional Life coverage in $10,000 increments up to $30,000 without medical evidence of good health.
- Employees can increase coverage beyond the $30,000 in $10,000 increments up to the maximum coverage level of $500,000 with medical evidence.
- Employees not currently enrolled in the Optional Life program can enroll in $10,000 increments up to $30,000 without medical evidence.
- Spouses of active employees, who are not themselves employees of a participating employer, can enroll or increase their level of coverage with medical evidence.
- Eligible children of active employees can be enrolled throughout the year without medical evidence.

Find what you're looking for on the EIP Web site

If you are looking for additional information about your benefits with the Employee Insurance Program (EIP), chances are you can find what you need without leaving your desk or picking up your phone. The EIP Web site is full of up-to-date information and breaking news about your benefits.

Best of all, the site is tailored just for you! All you have to do is visit the site at www.eip.sc.gov, and click on "Choose Your Category." You will then see a list of subscriber categories from which to choose, including Active Subscribers, COBRA Subscribers, Retirees, Spouses/Dependents, Survivors and more. Once you have selected your category, you will be given access to a list of resources and information tailored to fit your unique needs. You can:

- Find a participating dentist, doctor or pharmacy;
- Access and print forms for all EIP programs;
- Look up contact information for all of EIP's program administrators;
- Read EIP publications.

While you are visiting our site, be sure to check out other features, such as:

- "News & Updates" – Get the latest benefits information from EIP.
- "Prevention Partners" – Get valuable information about living life at its healthiest and to its fullest.
- "Insurance Managers" – Access the Web sites of EIP's plan administrators (such as BlueCross BlueShield of South Carolina and Companion HMO) where you can check the status of your claims, request a new ID card, check your deductible status, look for a drug on the prescription drug formulary and much more.
- "Links" – Find Web sites with information on state government, retirement benefits and much more.

More choices, more options, more savings

Continued from page 1

annual physical that will include specific services. Health information from a nurse will be available 24 hours a day by calling a toll-free number and from a self-care guide.

What about restrictions?

Chiropractic benefits will be limited to $500 a year, per covered person, after the deductible is met. Drugs that are not covered include non-sedating antihistamines and drugs for erectile dysfunction. Like the other plans, the Savings Plan does not cover drugs unless they are purchased at a network pharmacy.

What is a Health Savings Account (HSA)?

An HSA is a tax-free account that can be used to pay qualified medical expenses. Contributions do not have to be spent the year they are deposited. Money in the account earns interest and accumulates tax-free, so the funds can be used now and in the future. If an employee leaves his job, he can take the account with him and continue to use it for qualified healthcare expenses.

To be eligible for an HSA, the subscriber must be covered by a high-deductible health plan, such as the Savings Plan. He cannot be covered by any other health plan, including Medicare. However, accident, disability, dental, vision care and long-term care insurance coverage is permitted.

How much may I contribute?

Yearly contribution limits are adjusted for inflation. In 2004, the limit for subscriber-only coverage is $2,600; for subscriber/spouse, subscriber/children or full family coverage, it is $5,150. A subscriber age 55 or older may make "catch-up" contributions. In 2005, that amount will be $600.

Can an HSA participant contribute to a MoneyPlu$ Medical Spending Account?

"Limited-use" Medical Spending Accounts will be permitted for active employees. They may be used to pay expenses not covered by the health plan, such as dental and vision care.

What are the administrative costs? Who will be the administrator?

Employees who enroll in the HSA on a pretax basis through payroll deduction must enroll in MoneyPlu$. The MoneyPlu$ HSA will be administered by Fringe Benefits Management Company (FBMC), and the trustee will be NBSC, an affiliate of Synovus Financial Corp. HSA fees through the trustee are either a one-time fee of $20 per year or $2 per month – your choice! This fee includes up to two HSA Visa check cards, all transaction fees associated with the cards, a supply of checks, monthly statements and other banking services. An additional fee of 50 cents will be charged to process each HSA check. Additional fees may also apply for specific services.

The money in the MoneyPlu$ HSA account will earn interest at rates tied to a mutual fund index. The interest rate will depend on the account balance and account status.

Employees, who do not wish to contribute to an HSA on a pretax basis, and retirees, who cannot contribute on a pretax basis, may send their contributions directly to NBSC/Synovus or to any other HSA provider. These contributions are eligible deductions on an individual's federal income tax return.

How will a subscriber get access to the HSA to pay medical costs?

Participants in the HSA account maintained by NBSC will have access to funds at local NBSC branches, by check or by using a Visa check card that has no transaction fees. Both options will allow the subscriber to withdraw HSA funds from the account as qualified expenses are incurred, subject to fund availability. Since HSA reimbursements are substantiated by each participant, he can use the check card as often as necessary to pay qualified healthcare expenses. Participants should keep the receipts from HSA reimbursements in case the IRS performs an audit and requests copies.

For more information, contact your benefits administrator or EIP at one of the numbers listed on page 11.

SHP Standard Plan changes for 2005

If you are a State Health Plan (SHP) subscriber, you need to know what the changes will be for 2005 so, during October, you can choose the best health insurance plan for you.

Here are the SHP Standard Plan changes that will go into effect January 1, 2005:

- **Monthly premiums will increase for the SHP Standard Plan**. Refer to the rates on pages 8-9 for the new amounts.
- **The Standard Plan's coinsurance maximum for *out-of-network services* will increase** to $4,000/single and $8,000/family per year. This is the most money you would pay, after you meet your annual deductible, before the plan begins to pay 100 percent of the allowable charge for covered expenses. This limit does not include prescription drugs, deductibles, penalties for not calling Medi-Call or APS Healthcare or non-covered services.
- **The Standard Plan's prescription drug copayments for *mail service* (90-day supply) will increase** from $23 to $25 for generic drugs, from $56 to $62 for preferred brands and from $90 to $100 for non-preferred brands. Prescription drug copayments for participating retail pharmacies will remain the same. The pay-the-difference policy will remain in place.
- **The SHP's prescription drug program will implement a *coordination of benefits* provision consistent with the medical part of the Plan**. If you have other health insurance coverage, SHP Standard Plan benefits will be based on the benefits provided by your other insurance. Please read the article on page 10 for information on how coordination of benefits works.
- **The SHP will not cover gastric bypass surgery beginning January 1, 2005.**

HMO options for 2005

Like the State Health Plan, health maintenance organizations (HMOs) are making changes to their plans for 2005. Here are some of the major changes that will go into effect on January 1, 2005.

Not all HMOs are available in all counties. Refer to the chart on pages 6-7 for information on which counties offer the HMOs. You must live or work in a county in which an HMO is available to enroll in its plan.

Companion-CHOICES POS

Companion-CHOICES POS will not be offered for 2005. If you are enrolled in that plan, you must choose another plan during the October annual enrollment, or you will be enrolled in Companion HMO by default, effective January 1, 2005.

Companion HMO

- An annual deductible will be added: $250 individual and $500 family. This deductible does not apply to copayments for hospital services, physician office visits, emergency care or prescription drugs.
- While the copayments for physician office visits will not change, physician services provided in a hospital or in an inpatient or outpatient facility are subject to the annual deductible. After the deductible is satisfied, the coinsurance will apply.
- The emergency care copayment will increase from $75 to $100.
- The retail pharmacy prescription drug copayment (31-day supply) for generic drugs will increase from $7 to $8. The copayments for preferred and non-preferred brands and specialty pharmaceuticals will remain the same.
- The mail-order pharmacy prescription drug copayments (90-day supply) will decrease from $21 to $16 for generics, from $75 to $50 for preferred brands and from $120 to $80 for non-preferred brands.
- Companion HMO subscribers may participate in the SHP Prevention Partners Worksite Screening Program, if Companion is their primary insurance plan. Dependents are not eligible.

CIGNA HMO

- Retail pharmacy prescription drug copayments (30-day supply) will decrease from $10 to $7 for generic and will increase from $20 to $25 for preferred brands. The copayment for non-preferred brands will remain the same at $50.
- The mail-order pharmacy prescription drug copayments (90-day supply) will decrease from $20 to $14 for generics and will increase from $40 to $50 for preferred brands. The copayment for non-preferred brands will remain the same at $100.
- CIGNA HMO subscribers may participate in the SHP Prevention Partners Worksite Screening Program, if CIGNA is their primary insurance plan. Dependents are not eligible.

MUSC Options

- MUSC Options will be adding an urgent care benefit with a $35 per-visit copayment at participating urgent care providers.
- There will be no copayment for outpatient services provided at an MUSC outpatient facility.
- MUSC Options subscribers may participate in the SHP Prevention Partners Worksite Screening Program, if it is their primary insurance plan. Dependents are not eligible.

Which health plan is right for you?

With all the plans the Employee Insurance Program offers, how do you know what type of plan is right for you? Although needs and preferences differ from one subscriber to another, we hope the information at right might be helpful as you sort through your options for 2005. Be sure to review the comparison chart on the following pages for more details.

	Preferred Provider Organization (PPO)	Traditional HMO	HMO with Point-of-Service option	High Deductible Health Plan with Health Savings Account
What are they?	A health plan that provides greater benefit coverage when using a provider in its network of providers. The plan may reduce benefits when using providers outside of its network.	A health plan that may not allow coverage outside of its network of providers or service area (except in emergencies). Care is approved by the HMO and directed through a primary care physician, who handles referrals.	Similar in concept to an HMO in that care is directed through a primary care physician and approved by the HMO. However, it allows the subscriber to receive care outside of the network for lesser benefit coverage.	A low-cost health plan that encourages healthy lifestyles and thrift by setting high deductibles. Participants may use brand-name drugs and out-of-network providers, but save money by not doing so.
For whom are they designed?	A PPO is designed for individuals and families who want to make more of their own healthcare choices, but still want some coverage for routine medical expenses. Those with covered family members living or traveling out of state may find the out-of-network benefits helpful.	A traditional HMO is designed for those who want help managing their routine medical expenses, in addition to coverage for major healthcare expenses.	An HMO with a point-of-service (POS) option is designed for those who want help managing routine medical expenses, but who want the freedom to use a provider that is not in the HMO's network.	An HDHP plan is designed for those who are willing to take more responsibility for their routine medical expenses, in exchange for lower premiums and an optional tax-free Health Savings Account (HSA) that can help pay these expenses.
Which EIP plan offers this type of coverage?	**SHP Standard Plan**	**CIGNA HMO, Companion HMO**	**MUSC Options**	**SHP Savings Plan**

Comparison of health plans offered for 2005[1]

Plan	SHP Savings Plan		SHP Standard Plan		Companion HMO	CIGNA HMO	MUSC Options	
Availability	Coverage Worldwide		Coverage Worldwide		Available in all counties in S.C.	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*	Available in these S.C. counties: *Berkeley, Charleston, Colleton and Dorchester* counties	
Active Employee Monthly Premiums[2] *Employees Only* *Employee/Spouse* *Employee/Children* *Full Family*	**$ 9.28** **$ 72.56** **$ 20.28** **$108.56**		**$ 93.46** **$237.50** **$142.46** **$294.58**		**$101.58** **$309.24** **$226.36** **$464.00**	**$ 97.80** **$296.66** **$216.36** **$445.34**	**$ 99.02** **$288.40** **$190.34** **$374.00**	
Annual Deductible *Single* *Family*	**$3,000** **$6,000**		**$350** **$700**		**$250** **$500**	NONE	**In-network** NONE	**Out-of-network** **$300** **$900**
Coinsurance	**In-network** Plan Pays 80% You Pay 20%	**Out-of-network** Plan Pays 60 % You pay 40%	**In-network** Plan Pays 80% You Pay 20%	**Out-of-network** Plan Pays 60% You Pay 40 %	HMO pays 90% after copays You pay 10%	HMO pays 80% after copays You pay 20%	**In-network** HMO pays 100% after copays	**Out-of-network** HMO pays 60% of allowance You pay 40%
Coinsurance Maximum *Single* *Family*	**$2,000** **$4,000** **(excludes deductible)**	NONE	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**	**$1,500** **$3,000** **(excludes deductible)**	**$3,000** **$6,000** **(includes inpatient, outpatient, copays and coinsurance)**	N/A	**$3,000** **$9,000** **(excludes deductibles)**
Physicians Office Visits	Chiropractic benefits limited to $500 a year per person, after deductible No per-occurrence deductibles or copayments **In-network** Plan Pays 80% You Pay 20%	**Out of-network** Plan Pays: 60% You Pay 40% No preventive care benefits out-of-network	**$10 per visit deductible then**: **In-network** Plan Pays 80% You Pay 20%	**Out-of-network** Plan Pays 60% You Pay 40%	**$15** PCP copayment **$15** OB/GYN well woman exam **$25** specialist copay	**$20** PCP copayment **$40** OB/GYN well woman exam **$40** specialist copay	**$15** PCP copay **$15** OB/GYN well woman exam **$25** specialist copay with referral **$45** specialist copay without referral	HMO pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
Hospitalization/ Emergency Care	No per-occurrence deductibles or copayments		Outpatient hospital: **$75** per-occurrence deductible Emergency care: **$125** per occurrence deductible		Inpatient: **$200** copay Outpatient: **$75** copay/first 3 visits Emergency Care: **$100** copay HMO pays 90% after copays You pay 10% **$35** urgent care copay, then HMO pays 100%	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Inpatient: **$300** copay Outpatient Facility**:** **$100**[3] copay Emergency Care: **$100** copay **$35** urgent care copay	HMO pays 60% of allowance after annual deductible You pay 40% Emergency care: **$100** copay
Prescription Drugs	Participating pharmacies and mail order only: You pay the State Health Plan's allowable cost until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable cost; you pay 20%. When coinsurance maximum is reached, Plan will reimburse 100% of allowable cost.		Participating pharmacies only: **$10** generic **$25** preferred brand **$40** non-preferred brand (up to 31-day supply) Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand Out of pocket max: **$2,500**		Participating Pharmacies only **$8** generic **$25** preferred brand **$40** non-preferred brand **$75** specialty pharmaceuticals (31-day supply) Mail order (Up to 90-day supply): **$16** generic, **$50** preferred brand, **$80** non-preferred brand	Participating pharmacies only: **$7** generic **$25** preferred brand **$50** non-preferred brand (up to 30-day supply) Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand	Participating pharmacies only: **$10** generic **$25** preferred brand **$40** non-preferred brand (31-day supply) Mail order (90-day supply): **$15** generic, **$50** preferred brand, **$80** non-preferred brand	

[1]This table is for comparison purposes only.
[2]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[3]There will be no copayment for services performed at MUSC outpatient facilities.

Worksite Screenings Expanded for 2005

The Employee Insurance Program (EIP) Prevention Partners will be expanding its Worksite Screening Program, which has previously been available only to active employees and retirees enrolled in one of the State Health Plan options.

If your primary health insurance plan is the SHP Standard Plan, the SHP Savings Plan, Companion HMO, CIGNA HMO or MUSC Options, you will be eligible to receive one worksite screening per year, beginning in 2005. Dependents and retirees on Medicare are not eligible for a worksite screening.

The worksite screening includes: a health behavior risk appraisal; measurements of blood pressure, height and weight; and a comprehensive blood test including a lipid profile, blood chemistry profile and hemogram – all for a low copayment of only $15. The tests included in the worksite screening could cost up to $200 in other healthcare settings.

Within two weeks of the screening, you will receive your confidential, personalized, health profile report. The tests and measurements taken during the screening are evaluated to create this report, which offers a broad view of your overall health and identifies personal health risk factors for conditions such as diabetes, heart disease and cancer. You can send this report to your physician or take a copy with you to your next office visit, saving you money and eliminating the need for your doctor to run duplicate tests.

Worksite screenings are available through Prevention Partners. You can ask the Prevention Partners coordinator at your worksite about scheduling a screening for your office, or you may participate in one of the regional screenings that are held each month at a different location around the state.

For more information on the worksite screening program, including a schedule of upcoming regional screenings, visit the EIP Web site at www.eip.sc.gov, choose the "Prevention Partners" link, then click on "Early Detection."

2005 Active Employee Monthly Premiums[1]

State Health Plan

	SAVINGS	STANDARD	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Employee	$ 9.28	$ 93.46	$101.58	$ 97.80	$ 99.02	$0.00	$ 0.00	$17.50
Employee/spouse	$ 72.56	$237.50	$309.24	$296.66	$288.40	$0.00	$ 7.64	$33.14
Employee/children	$ 20.28	$142.46	$226.36	$216.36	$190.34	$0.00	$13.72	$36.16
Full family	$108.56	$294.58	$464.00	$445.34	$374.00	$0.00	$21.34	$51.80

[1]Rates for employees of local subdivisions may vary. To verify your rates, contact your benefits office.

2005 Regular Retiree (State-Funded Benefits) Monthly Premiums[1]

(Retiree entitled to Medicare/spouse entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	N/A	$ 78.74	$ 96.74	$101.58	$ 97.80	N/A	N/A	$ 0.00	$17.50
Retiree/spouse	N/A	$210.44	$246.44	$309.24	$296.66	N/A	N/A	$ 7.64	$33.14
Retiree/children	N/A	$127.74	$145.74	$226.36	$216.36	N/A	N/A	$13.72	$36.16
Full family	N/A	$259.44	$295.44	$464.00	$445.34	N/A	N/A	$21.34	$51.80

(Retiree entitled to Medicare/spouse not entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$222.78	$240.78	$309.24	$296.66	N/A	N/A	$ 7.64	$33.14
Full family	N/A	$271.78	$289.78	$464.00	$445.34	N/A	N/A	$21.34	$51.80

(Retiree not entitled to Medicare/spouse entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$225.16	$243.16	$309.24	$296.66	N/A	N/A	$ 7.64	$33.14
Full family	N/A	$274.16	$292.16	$464.00	$445.34	N/A	N/A	$21.34	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	$ 9.28	$ 93.46	N/A	$101.58	$ 97.80	$ 99.02	$ 0.00	$ 0.00	$17.50
Retiree/spouse	$ 72.56	$237.50	N/A	$309.24	$296.66	$288.40	$ 0.00	$ 7.64	$33.14
Retiree/children	$ 20.28	$142.46	N/A	$226.36	$216.36	$190.34	$ 0.00	$13.72	$36.16
Full family	$108.56	$294.58	N/A	$464.00	$445.34	$374.00	$ 0.00	$21.34	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare/one or more children entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/children	N/A	$142.46	$160.46	$226.36	$216.36	N/A	N/A	$13.72	$36.16
Full family	N/A	$294.58	$312.58	$464.00	$445.34	N/A	N/A	$21.34	$51.80

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental Plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard Plan provisions.

2005 COBRA Monthly Premiums

18 and 36 months

	SAVINGS	STANDARD	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Subscriber only	$235.48	$321.34	$329.62	$325.78	$327.02	N/A	$11.94	$17.85
Subscriber/spouse	$514.24	$682.48	$755.66	$742.84	$734.40	N/A	$19.74	$33.80
Subscriber/children	$339.54	$464.16	$549.74	$539.54	$513.00	N/A	$25.94	$36.88
Family	$624.26	$814.00	$986.82	$967.78	$895.02	N/A	$33.71	$52.84
Children (to age 18)	$104.06	$142.82	$220.12	$213.76	$185.98	N/A	$13.99	$19.03

29 months **(These rates go into effect in the 19th month of coverage for 29-month COBRA subscribers.)**

	SAVINGS	STANDARD	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Subscriber only	$ 346.30	$ 472.56	$ 484.74	$ 479.08	$ 480.90	N/A	$11.94	$17.85
Subscriber/spouse	$ 756.24	$ 1,003.66	$ 1,111.26	$1,092.40	$ 1,080.00	N/A	$19.74	$33.80
Subscriber/children	$ 499.32	$ 682.60	$ 808.44	$ 793.44	$ 754.42	N/A	$25.94	$36.88
Family	$ 918.04	$1,197.06	$ 1,451.20	$1,423.20	$ 1,316.20	N/A	$33.71	$52.84
Children (to age 18)	$ 153.02	$ 210.04	$ 323.70	$ 314.36	$ 273.52	N/A	$13.99	$19.03

2005 Retiree Full Cost (non-funded) Monthly Premiums[1]

(Retiree entitled to Medicare/spouse entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	N/A	$300.32	$318.32	$323.16	$319.38	N/A	N/A	$11.71	$17.50
Retiree/spouse	N/A	$642.04	$678.04	$740.84	$728.26	N/A	N/A	$19.35	$33.14
Retiree/children	N/A	$440.34	$458.34	$538.96	$528.96	N/A	N/A	$25.43	$36.16
Full family	N/A	$762.90	$798.90	$967.46	$948.80	N/A	N/A	$33.05	$51.80

(Retiree entitled to Medicare/spouse not entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$654.38	$672.38	$740.84	$728.26	N/A	N/A	$19.35	$33.14
Full family	N/A	$775.24	$793.24	$967.46	$948.80	N/A	N/A	$33.05	$51.80

(Retiree not entitled to Medicare/spouse entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$656.76	$674.76	$740.84	$728.26	N/A	N/A	$19.35	$33.14
Full family	N/A	$777.62	$795.62	$967.46	$948.80	N/A	N/A	$33.05	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	$230.86	$315.04	N/A	$323.16	$319.38	$320.60	$ 63.50	$11.71	$17.50
Retiree/spouse	$504.16	$669.10	N/A	$740.84	$728.26	$720.00	$122.50	$19.35	$33.14
Retiree/children	$332.88	$455.06	N/A	$538.96	$528.96	$502.94	$122.50	$25.43	$36.16
Full family	$612.02	$798.04	N/A	$967.46	$948.80	$877.46	$163.50	$33.05	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare/one or more children entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/children	N/A	$455.06	$473.06	$538.96	$528.96	N/A	N/A	$25.43	$36.16
Full family	N/A	$798.04	$816.04	$967.46	$948.80	N/A	N/A	$33.05	$51.80

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental Plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard Plan provisions.

2005 Survivor Monthly Premiums[1]

(Spouse entitled to Medicare/children entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	N/A	$300.32	$318.32	$323.16	$319.38	N/A	N/A	$11.71	$17.50
Spouse/children	N/A	$440.34	$476.34	$538.96	$528.96	N/A	N/A	$25.43	$36.16
Children only	N/A	$140.02	$158.02[3]	$215.80	$209.58	N/A	N/A	$13.72	$18.66

(Spouse entitled to Medicare/children not entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	N/A	$300.32	$318.32	$323.16	$319.38	N/A	N/A	$11.71	$17.50
Spouse/children	N/A	$440.34	$458.34	$538.96	$528.96	N/A	N/A	$25.43	$36.16
Children only	$102.02	$140.02	N/A	$215.80	$209.58	$182.34	N/A	$13.72	$18.66

(Spouse not entitled to Medicare/children entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	$230.86	$315.04	N/A	$323.16	$319.38	$320.60	N/A	$11.71	$17.50
Spouse/children	N/A	$455.06	$473.06	$538.96	$528.96	N/A	N/A	$25.43	$36.16
Children only	N/A	$140.02	$158.02[3]	$215.80	$209.58	N/A	N/A	$13.72	$18.66

(Spouse not entitled to Medicare/children not entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	$230.86	$315.04	N/A	$323.16	$319.38	$320.60	$ 63.50	$11.71	$17.50
Spouse/children	$332.88	$455.06	N/A	$538.96	$528.96	$502.94	$122.50	$25.43	$36.16
Children only	$102.02	$140.02	N/A	$215.80	$209.58	$182.34	$ 63.50	$13.72	$18.66

[1]Plan premiums for spouses and dependents will be waived for one year after the death of the funded employee or retiree for those covered as dependents under the Plan at the time of death.
[2]If the Medicare Supplemental Plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard Plan provisions.
[3]This premium applies only if one or more children are entitled to Medicare.

New debit card offered to MoneyPlu$ MSA participants for 2005

In October, when employees enroll or re-enroll in a Medical Spending Account (MSA), they also may sign up for the new EZ REIMBURSE® MasterCard® Card, which is issued by BANKFIRST through Fringe Benefits Management Company (FBMC).

What is an EZ REIMBURSE® Card?

It works like a debit card. The card transfers funds for eligible medical expenses directly from the MSA to the provider. If there is not enough in the account, the transaction will be denied.

Where may I use it?

A participant may use the card at the doctor's office, dentist's office, hospital, pharmacy or vision care provider. It may pay for eligible medical expenses, such as copayments, deductibles and other expenses that are not reimbursed by insurance. A list of IRS-approved expenses is on the FBMC Web site at www.fbmc-benefits.com. A participant may *not* use the card to pay for services received in the past.

If the provider cannot accept MasterCard®, the participant may request reimbursement through the mail, using the Reimbursement Request form on the EIP Web site, www.eip.sc.gov.

Will I need to provide documentation?

Some expenses, such as pharmacy or doctor's visit copayments, may be authorized at the point of sale. Others may require documentation, such as a receipt or Explanation of Benefits. Participants' monthly statements will show any documentation needed.

What does it cost to use it?

A $20 annual fee will be deducted from the MSA at the start of the year. This is in addition to the monthly $2.50

Continued on page 12

Prescription Drugs: How You Can Help Keep them Affordable

Whether your toddler has an ear infection or your spouse has arthritis, prescription drugs are important in treating their illnesses. But drugs costs are increasing rapidly. In 2003, State Health Plan prescription drug payments totaled $276.9 million, a 21 percent increase over 2002.

To continue to provide affordable insurance, the Employee Insurance Program (EIP), needs to control drug costs. Here is how you can help:

Know the preferred drug list

This list of effective, economical drugs was prepared by an independent committee of doctors and pharmacists. By asking your doctor to prescribe drugs from it, you and the plan save money.

Medications purchased through the Prescription Drug Program at participating pharmacies fall into these categories:

- **Non-preferred drugs.** These brand-name products are not on the list. They are the most expensive.
- **Preferred-brand drugs.** They are on the list and cost less than non-preferred drugs.
- **Generic drugs.** They are least expensive.

Choose generics

Generic drugs are a great way to save. Although they may look different from their brand-name equivalents, they have the same active ingredients.

A generic drug is less costly because the patent, a company's exclusive right to sell a product it developed, has expired. However, your doctor should always make the final decision about which drug is best for you.

Coordinate benefits to avoid "double dipping"

Beginning January 1, the Prescription Drug Program will implement a **coordination of benefits (COB)** provision.

How COB works

For persons covered by more than one health insurance plan, COB ensures the subscriber is not reimbursed more than once for the same medical expense. Under COB:

- The plan that pays first is *primary*.
- The *secondary* plan pays after the primary plan.

When a person is covered by more than one plan, the SHP determines which plan is primary and which is secondary. Here are two examples:

- The plan that covers a person as an employee is primary to the plan that covers him as a dependent.
- When both spouses' plans cover a child, the plan of the parent whose birthday is earlier in the year is primary.

Coordinating benefits ensures that the SHP and the other insurance company pay a fair share, but that the combined payments do not exceed the maximum allowable reimbursement and 100 percent of the claim.

How the new COB provision will affect prescription drug purchases

When filling a prescription, subscribers who have other insurance may notice a difference in the amount the SHP pays.

If SHP is primary

Present your SHP group insurance card first. If you don't, the claim will be processed as if you have no other coverage. Then present your secondary insurance card so that any benefits under that plan may be paid.

If SHP is secondary

Present your primary insurance card first, as the claim will be denied if the SHP is indicated as secondary. The pharmacy may process the claim through the primary plan and then through the SHP at the point of sale.

If the pharmacy cannot process secondary claims electronically, the claim may be denied. If this happens, file a paper claim for any SHP benefits. Prescription drug claim forms are available on the EIP Web site at www.eip.sc.gov. Choose your category, then click on "Forms."

Note: The SHP will not file or process a subscriber's claims through another insurance plan; that is the subscriber's responsibility.

Questions? Here's where to get answers

AETNA Long Term Care

- Customer Service Phone: 800-537-8521
- Fax: 860-952-2024
- Web: www.aetna.com/group/southcarolina

APS Healthcare Inc. – State Mental Health and Substance Abuse

- Customer Service Phone: 800-221-8699
- Fax: 888-897-8931
- Web: www.apshealthcare.com (password: statesc)

ASI – TRICARE Supplement Plan

- Customer Service Phone: 800-638-2610, ext. 255
- Fax: 301-816-1125
- Web: www.corporatetricaresupp.com www.tricare.osd.mil

BlueCross BlueShield Of South Carolina

- Customer Service Phone – Health: 803-736-1576 (Greater Columbia area) 800-868-2520 (toll-free outside Columbia area)
- Fax – Health: 803-699-7675
- Medi-Call: 803-699-3337 (Greater Columbia area) 800-925-9724 (toll-free outside Columbia area)
- Fax –Medi-Call: 803-264-0183
- BlueCard Program Phone: 800-810-BLUE (2583)
- Customer Service Phone – Dental: 888-214-6230
- Fax – Dental: 803-419-3283
- Web: www.southcarolinablues.com

CIGNA Healthcare HMO

- Member Services Phone: 800-244-6224
- Web: www.cigna.com

Companion HealthCare HMO

- Member Services Phone: 803-786-8476 (Greater Columbia area)
- 800-868-2528 (toll-free outside Columbia area)
- Web: www.CompanionHealthCare.com

Fringe Benefits Management Company

- Customer Service Phone: 800-342-8017
- Fax – Claims: 850-425-4608
- Fax – Other: 850-425-6220
- Web: www.fbmc-benefits.com

The Hartford

- Evidence of Insurability Phone: 800-331-7234
- Death Claims Phone: 888-563-1124
- Retiree/Enrollment/Claims Phone: 888-803-7346, ext. 3648
- Conversion Phone: 800-548-5157

Medco Health

- Customer Service Phone: 800-711-3450
- Web: www.medcohealth.com

MUSC Options

- Member Services Phone: 800-821-3023
- Web: www.CompanionHealthCare.com

The Standard

- Customer Service Phone: 800-628-9696
- Fax: 800-437-0961
- Medical Evidence Phone: 800-843-7979
- Web: www.standard.com

EIP's new phone system answers your questions more efficiently

The Employee Insurance Program (EIP) has implemented a new, automated telephone system designed to help us serve you more efficiently. Our contact numbers, e-mail address and Web address will not be changing. You will still reach us at:

- **Subscriber Services Phone:** 803-734-0678 (Greater Columbia area) 888-260-9430 (toll-free outside Columbia area)
- **Accounting and Billing Phone:** 803-734-1696
- **Fax:** 803-737-0825
- **Subscriber Services E-mail:** cs@eip.sc.gov
- **Web:** www.eip.sc.gov

When you call EIP, you will be asked a series of automated questions designed to help us determine the best way to assist you. For example, if you call with a question about a claim, the automated system will ask you if you have contacted your insurance carrier (such as BlueCross BlueShield of South Carolina, Companion Healthcare, Aetna, etc.) with this question. If you respond that you have not addressed the question with your insurance carrier, the automated system will connect you directly to the carrier, putting you in touch with the people best able to assist you in this matter.

If you are unsure about any information requested, or if you need assistance during your interaction with the new system, you can reach an EIP Subscriber Services Representative at any point by simply choosing that option from the automated menu.

We also will be asking for your feedback on our services. Once you have finished speaking with one of our Subscriber Services Representatives, you will have the opportunity to complete a customer satisfaction survey that will help us make sure that the new system is serving your needs.

New debit card

Continued from page 10

administrative fee.

Before January 1, the participant will receive his card, along with:

- A cardholder agreement;
- Information on how and where to use the card;
- Information on how to dispute a transaction; and
- Information on how to report a lost or stolen card (replaced free).

The participant must call the toll-free number on the back of the card before he can use it. The card is good for three years, if the participant continues to re-enroll in an MSA.

One additional free EZ REIMBURSE® Card for eligible family members may be requested by calling FBMC's customer service line.

The EZ REIMBURSE® Card will not be available to employees who enroll in the "limited-use" MSA, described on page 4. Those establishing a MoneyPlu$ Health Savings Account (HSA) will be issued a Visa check card to use with their HSA.

More questions?

FBMC's Web site lists of frequently asked questions about the card. Visit www.fbmc-benefits.com or call 800-342-8017.

Vision Care Program

The State Vision Care Program is available to all full-time and part-time state employees, dependents, retirees, survivors and COBRA subscribers. A routine comprehensive eye exam costs $60, effective January 1, 2005, and a 20 percent discount is available on all eyewear, except disposable contacts. Three important reminders about the Program:

1. **Vision Care is a discount program**; there are no claims to file, and you receive your discount at the time of service.
2. **Not all providers participate**. In order for you to take advantage of the Program, you need to use a participating provider. To locate a participating provider, go to the Employee Insurance Program (EIP) Web site at www.eip.sc.gov, then "Choose Your Category" and select "Online Directories." Then, click on "Vision Care" to search for providers.
3. **It is important to tell your provider you are a participant in the state Vision Care Program**; if you do not, you may not receive the discount.

For more information refer to 2005 *Insurance Benefits Guide*, which you will be receiving in January.

Total printing cost: $17273; Total number printed: 310,000; Unit cost: $.056

S.C. Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, S.C. 29211

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